Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ST DAVID'S REHABILITATION OAK HOSPITAL
3701 KIRBY DRIVE SUITE 1288
HOUSTON TX 77098-3916

Respondent Name

HARTFORD CASUALTY INSURANCE CO

Carrier's Austin Representative Box

Box Number 47

MFDR Tracking Number

M4-13-0993-01

MFDR Date Received

DECEMBER 14, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "There is no evidence provided by the carrier that the disputed charges were not billed at the hospital's usual and customary rate…The fees paid by the Carrier in this case do not conform to the reimbursement section of Rule § 134.404. Rules 134.403 and 134.404 are for outpatient and inpatient medical services, which are provided in an acute care hospital. TDI, DWC does not have a fee guideline for inpatient rehabilitation facilities. In absence of a negotiated contract, those services would be reimbursed at 'fair & reasonable' in accordance with Rule 134.1. Therefore, our client's claim would be reimbursed at 'fair & reasonable' at 100% of total billed charges."

Amount in Dispute: $50,224.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Our investigation finds that reimbursement was based upon the Medicare rate for inpatient rehabilitation."

Response Submitted by: The Hartford

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
March 7, 2012 through March 28, 2012	Rehabilitation Hospital Services	$50,224.80	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.1 sets forth general provisions related to medical reimbursement.
3. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - W1-WC state fee sched adjust. Reimbursement according to the Texas medical fee guidelines.
   - W1-Workers compensation state fee schedule adjustment. Payment of services are included in the visit

rate.

- 193-Original payment decision is being maintained. Reimbursement for your no additional monies are being paid at this time bill has been paid according to state fee guidelines or rules and regulations.
- 193-Original payment decision is being maintained. Final action. In accordance with rule 133.250(G): 'A health care provider shall not resubmit a request for reconsideration after the carrier has taken final action on the request."

Findings

1. This dispute relates to services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.1, effective March 1, 2008, 33 *Texas Register* 626, which requires that, in the absence of an applicable fee guideline or a negotiated contract, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection 134.1(f), which states that "Fair and reasonable reimbursement shall: (1) be consistent with the criteria of Labor Code §413.011; (2) ensure that similar procedures provided in similar circumstances receive similar reimbursement; and (3) be based on nationally recognized published studies, published Division medical dispute decisions, and/or values assigned for services involving similar work and resource commitments, if available."
2. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
3. Former 28 Texas Administrative Code §133.307(c)(2)(O), effective May 31, 2012, 37 *Texas Register* 3833, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) or §134.503 of this title (relating to Pharmacy Fee Guideline) when the dispute involves health care for which the division has not established a maximum allowable reimbursement (MAR) or reimbursement rate, as applicable." Review of the submitted documentation finds that:
   - The requestor states in the position summary that "There is no evidence provided by the carrier that the disputed charges were not billed at the hospital's usual and customary rate…The fees paid by the Carrier in this case do not conform to the reimbursement section of Rule § 134.404. Rules 134.403 and 134.404 are for outpatient and inpatient medical services, which are provided in an acute care hospital. TDI, DWC does not have a fee guideline for inpatient rehabilitation facilities. In absence of a negotiated contract, those services would be reimbursed at 'fair & reasonable' in accordance with Rule 134.1. Therefore, our client's claim would be reimbursed at 'fair & reasonable' at 100% of total billed charges."
   - The requestor did not submit documentation to support that 100% of total billed charges is fair and reasonable in accordance with Rule 134.1.
   - The requestor does not discuss or explain how 100% of total billed charges supports the requestor's position that the amount sought is a fair and reasonable reimbursement for the services in this dispute.
   - The requestor did not provide documentation to demonstrate how it determined its usual and customary charges for the disputed services.
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.
   - The Division has previously found, as stated in the adoption preamble to the former *Acute Care Inpatient Hospital Fee Guideline,* that "hospital charges are not a valid indicator of a hospital's costs of providing services nor of what is being paid by other payors" (22 *Texas Register* 6271). The Division further considered alternative methods of reimbursement that use hospital charges as their basis; such methods were rejected because they "allow the hospitals to affect their reimbursement by inflating their charges" (22 *Texas Register* 6268-6269). Therefore, the use of a hospital's "usual and customary" charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - The Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:

     > A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard

not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.

Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.

- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the submitted documentation finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		10/18/2013
Signature	Medical Fee Dispute Resolution Officer	Date
		10/18/2013
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.